UNITED
NATIONS

E

Economic and Social
Council

Distr.
GENERAL

E/CN.7/1997/3
17 February 1997

ORIGINAL: ENGLISH

COMMISSION ON NARCOTIC DRUGS
Fortieth session
Vienna, 18-27 March 1997
Item 5 of the provisional agenda*

ILLICIT DEMAND FOR DRUGS

World situation with regard to drug abuse

Report of the Secretariat

Summary

The present report attempts to describe the world situation with regard to drug abuse and the demand reduction activities that Governments have pursued in response to the targets set out in the Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control. The report builds mainly on information provided by Governments through the annual reports questionnaires.

A review of those questionnaires is now being carried out within the United Nations International Drug Control Programme. Generally speaking, the abuse of amphetamines, cannabis and opiates seem to be on the increase, while the abuse of cocaine and hallucinogens is stable but at high levels. Cannabis is the most frequently reported drug of abuse, with all regions of the world reporting its abuse. It seems also to be the most prevalent drug among the general population. Most of the countries reporting opiate abuse also reported a steadily increasing trend. Several countries reported an increase in drug abuse by young people. Furthermore, there are indications that the initiation into drug abuse is taking place at an earlier age than before.

Judging from what Governments report on demand reduction, school activities are the most widespread form of prevention across the world. Although street children and school drop-outs are recognized as being at the highest risk for drug abuse, only few activities were reported as targeting those groups.

Most countries responding to the annual reports questionnaire stated that they did not have an articulated treatment policy. Treatment is carried out in various settings. In addition to medicated detoxification, traditional medicine models and acupuncture treatment is available in some countries. Generally speaking, social reintegration seems to be the least addressed aspect of demand reduction.

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INTRODUCTION

1. Any State party to the international drug control treaties has a treaty obligation to furnish the Secretary-General with information. While there is no such obligation for non-parties to the treaties, their cooperation is encouraged. The annual reports questionnaires are the main source of information about the drug abuse situation and the responses to it in individual countries. Countries are also encouraged to supplement their annual reports questionnaire with reports from surveys or other research. The present report is based mainly on data contained in the 1995 annual reports submitted during the second half of 1996 by Governments to the secretariat of the Commission on Narcotic Drugs, supplemented where available with other official data.

I. THE EXTENT AND PATTERNS OF DRUG ABUSE IN THE WORLD

A. Prevalence* of drug abuse by drug type

2. In 1995, 90 countries out of 192 recipients provided information on the demand reduction part of the annual reports questionnaire, but only 37 provided estimated numbers of drug abusers for 1995. For the preparation of the present report, figures for 1995 were supplemented with data from 1992, 1993 and 1994, the assumption being that countries reporting occurrence of abuse of a particular drug in those recent years were likely to have had a similar drug abuse population in 1995, unless a change had been indicated. Prevalence rates have been calculated on the basis of reported numbers of abusers of drugs as classified in the annual reports questionnaire** and figures on the total population for each reporting year provided by the Statistics Division of the Secretariat.[1] Map I shows the geographical distribution of the countries and territories that provided annual reports to the United Nations International Drug Control Programme (UNDCP) in 1995.

3. It should be noted that the data are not directly comparable. Different countries collect different data, using different data collection instruments and assumptions about the nature of the problem. Some countries estimate the number of annual drug abusers on the basis of figures provided by the treatment system, others base their estimates on surveys the results of which have been extrapolated to the rest of the population. Since the basis for the estimates is so varied and the number of reporting countries not equally spread over the regions of the world, it is not possible to extrapolate to the global level the figures reported by individual countries.

4. Drug abuse is by its nature a very private and secretive act. It is therefore more probable that the numbers of drug abusers are underestimated than the opposite. Furthermore, it can be assumed that high-prevalence rates for a certain drug of abuse indicate that the particular drug is actually more prevalent than drugs with reported lower prevalence rates. The conclusion may thus be drawn that even though more countries have reported abuse of opiates, the prevalence rates (the highest rates ranging from 0.9 to 1.8 per cent) indicate that opiate abuse is less prevalent among the general population than, for example, the abuse of sedatives where the highest prevalence rates range from 5.5 to 25 per cent.

5. *Cannabis-type drugs* refer to cannabis products such as hashish and marijuana. The concentration of the active substance tetrahydrocannabinol (THC) varies widely, depending on the part of the plant used and where it is grown. Hashish refers to cannabis resin, while marijuana usually refers to the dried parts of the plant.

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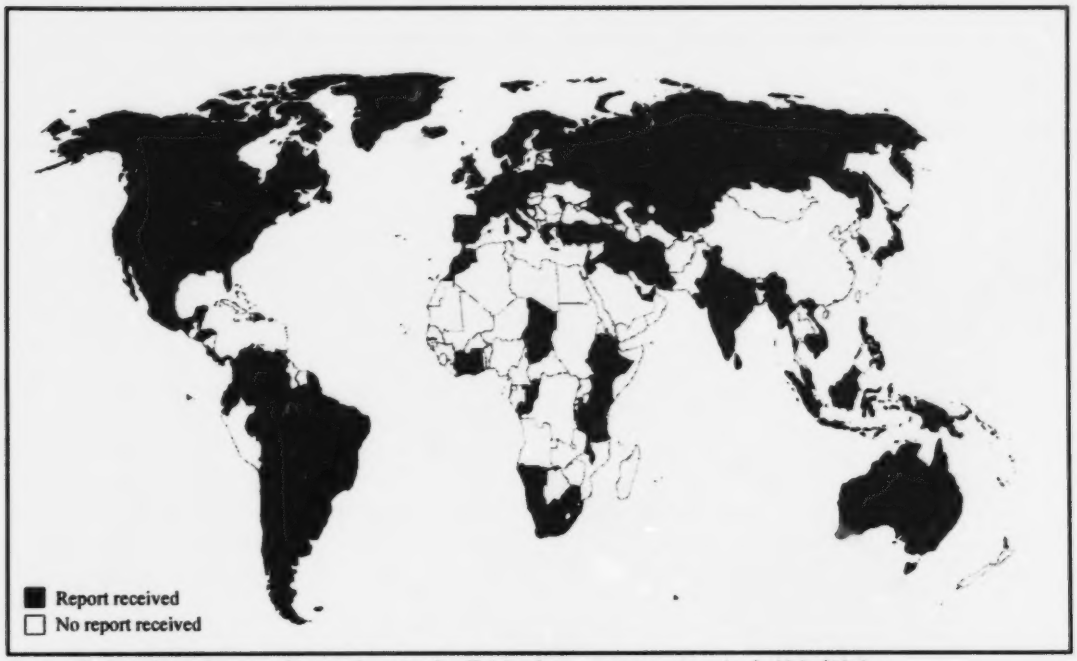
* The term "prevalence" is used here to indicate the percentage of drug abusers in the total population.

**Drugs are classified in the annual reports questionnaire as follows: opiate-type (opium, heroin, morphine, other opiates, synthetic narcotic analgesics); cocaine-type (cocaine (base and salt), coca paste); cannabis-type; hallucinogens; amphetamine-type (amphetamine, methamphetamine, other amphetamines); sedative-type (barbiturates, benzodiazepines, other sedatives); multiple drugs (if not in the above categories); and volatile solvents (inhalants).

Map 1. Geographical distribution of countries and territories providing reports to the United Nations International Drug Control Programme in 1995



Note: The boundaries shown on this map do not imply official endorsement or acceptance by the United Nations.

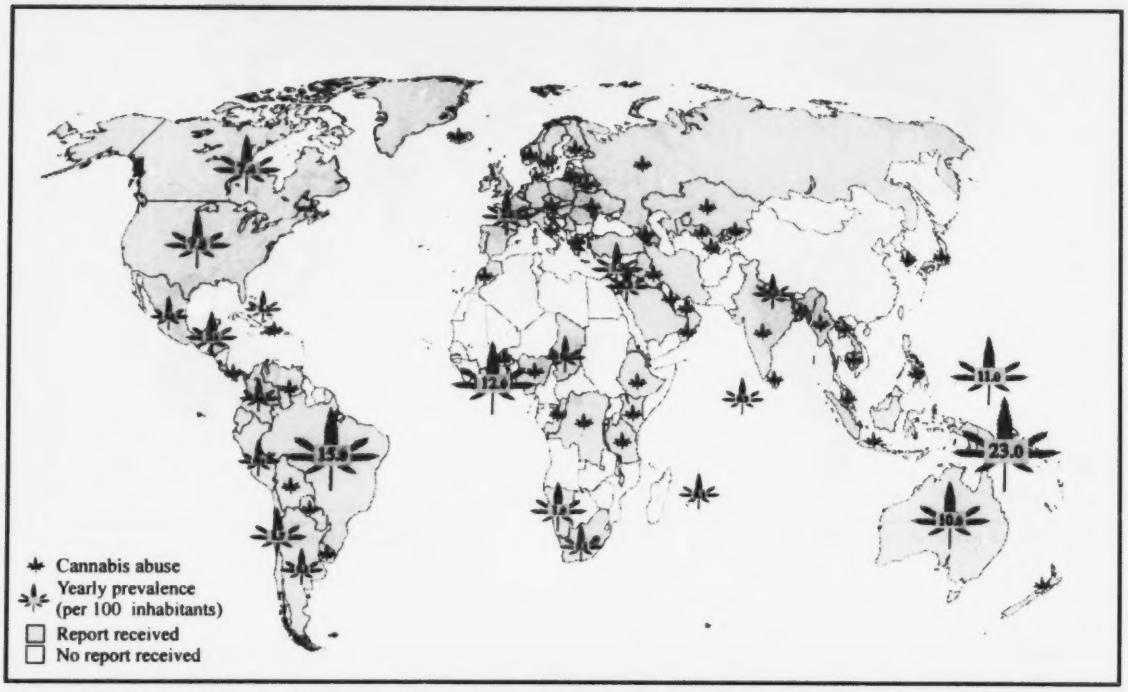
6. Cannabis is the most frequently reported drug of abuse, with all regions of the world reporting its abuse. Through the annual reports questionnaire data, an estimated 48.5 million abusers were reported by 73 countries. In terms of annual prevalence of cannabis abuse, Oceania was the subregion with the highest reported prevalence (Papua New Guinea 23.5 per cent, the Federated States of Micronesia 11.4 per cent and Australia 10.3 per cent) while east and south-east Asia had the lowest reported rates (Nepal 0.7 per cent, Maldives 0.2 per cent). The Netherlands stands out with a reported monthly prevalence of 4.4 per cent. Other high annual prevalence countries in Europe are Slovenia (4 per cent), Denmark (3.3 per cent), Switzerland (2.4 per cent), Croatia (1.9 per cent), Czech Republic (1.5 per cent), Germany (1.2 per cent) and Portugal (1 per cent). In the Middle East, Israel has reported high annual prevalence (1.5 per cent). Map 2 shows cannabis abuse per 100 inhabitants.

7. *Opiate-type drugs*, according to the annual reports questionnaire classification, include opium, heroin, morphine, other opiates and synthetic narcotic analgesics, including pethidine, meperidine, methadone and fentanyl. Opiate-type drugs provide relief of pain, calm nerves, may reduce hunger pain and reduce nausea and vomiting, and may produce euphoria. The risk of contracting infections like hepatitis and human immunodeficiency virus (HIV) because of sharing of injecting equipment is well known. Opiate abuse may mask underlying medical problems such as inflammation and infections because of the analgesic effect of the drugs. Death can be caused by difficulty in breathing and cardiac arrest.

8. Opiate-type drugs were the second most frequently reported drugs of abuse, with 69 countries reporting 1.2 million abusers. It should be noted, however, that even though the number of reporting countries was comparatively high, several major opiate consumption countries did not provide any estimates of the number

of abusers in their countries. It can therefore be assumed that the reported number of abusers represents a considerable underestimation of the real number of abusers in the world.

Map 2. Cannabis abuse per 100 inhabitants, 1992-1995[a/]



Source: United Nations International Drug Control Programme, an nual reports questionnaire, part II, Drug abuse, 1992-1995.

Note: The boundaries shown on this map do not imply official en orsement or acceptance by the United Nations.

[a/] Most recent figures provided.

9. Most of the countries reporting opiate abuse also reported a steadily increasing trend. High rates of opiate abuse have been reported by all regions of the world except for the Caribbean. High prevalence of heroin abuse was reported by the United States of America (1.8 per cent), Brazil (1 per cent) and Portugal (0.6 per cent). As for other types of opiates, Bolivia reported an annual prevalence of abuse of synthetic narcotic analgesics amounting to 0.9 per cent, while the Lao People's Democratic Republic reported the same prevalence rates for annual and daily opium abuse.

10. *Sedative-type drugs* refer to barbiturates, benzodiazepines and other sedatives, for example, methaqualone. Barbiturate overdose may result in poisoning death. Benzodiazepines such as flunitrazepam (Rohypnol), diazepam (Valium) and chlordiazepoxide (Librium) are more popular than barbiturates.

11. Abuse of sedatives has been reported by 55 countries with an estimated 46.4 million abusers. Many countries reporting illicit consumption of sedatives reported a gradual stabilization of consumption. Among the

countries reporting high annual prevalence are Brazil (25 per cent) and Papua New Guinea (22.9 per cent). Other high-prevalence countries are Honduras (7.6 per cent), Chile (5.5 per cent), Colombia (3.4 per cent), Ghana (3 per cent), Namibia (2 per cent), Bolivia (1.8 per cent), Mexico (1.3 per cent), Israel and United States (both 1 per cent). Denmark reported a daily prevalence of 2.7 per cent.

12. *Cocaine-type drugs* refer to cocaine (base and salts) and coca paste. Cocaine is a stimulant to the central nervous system. It is also a local analgesic. It can be inhaled ("snorting"), but can also be injected or applied directly to a mucous membrane. Overdoses of cocaine can lead to convulsive fits, heart paralysis or high fever.

13. Cocaine abuse was reported by 51 countries and the number of abusers estimated at 10.9 million. Cocaine consumption seems to be stabilizing. Countries reporting high annual prevalence were Argentina (4.4 per cent), Brazil (2 per cent) and the United States (1.7 per cent). There were no reports of cocaine abuse in south and central Asia, but seizures of cocaine have been reported in India.

14. *Amphetamine-type drugs* refer to amphetamine, methamphetamine ("ice") and other amphetamines. They are central nervous system stimulants and anorectics. They can be taken as tablets or capsules, be inhaled or injected. Over time, the suppression of the sensations of hunger and fatigue can lead to malnutrition and complete exhaustion and collapse, a cause of traffic accidents among truck and bus drivers who abuse these drugs. Methylenedioxymethamphetamine (MDMA) ("ecstasy") has both a stimulant and a hallucinogenic effect.

15. The number of abusers of amphetamine-type drugs was estimated at 6 million from among 37 reporting countries, with Europe being the leading region, followed by the Americas. A majority of countries reported ingestion as the most frequent method of administration, followed by injection. Honduras (7.6 per cent), Brazil (2 per cent) and Australia (1.7 per cent) were the countries that, through the annual reports questionnaires, reported the highest annual prevalence rates.

16. *Hallucinogens* such as lysergic acid diethylamide (LSD) may produce an altered state of consciousness with auditory and/or visual perceptions.

17. There were some of 2.9 million hallucinogen abusers reported from 26 countries covering most regions except western Asia. The countries reporting high prevalence were Australia (1.3 per cent), Brazil and the United States (both just under 1 per cent). The table provides a list of countries that reported ≥ 0.1 per cent prevalence on at least one of the above drug types between 1992 and 1995.

B. Drug abuse by injection

18. Injecting drug users (IDUs) are the second largest group at risk for HIV infection in the Americas and Europe.[2] Injecting drug use practice is not limited to intravenous injecting, but also include intramuscular or subcutaneous injecting. The generic term "injecting drug use" has therefore been considered to reflect more accurately the actual practice and behaviour.

19. In order to present a fuller picture of the situation, data provided through the annual reports questionnaires have has been supplemented by other data.[3] Injecting drug use has been reported by 121 countries and territories. Of these, 71 countries reported having HIV-positive cases among identified IDUs. Map 3shows the distribution of countries reporting injecting drug use and indicates those countries reporting HIV infection among IDUs.

Table. Estimates of prevalence of drug abuse, by drug type and by country or territory, 1992-1995
(Percentage of drug abusers in the total population)

Country/territory	*Opiate-type drugs*	*Cocaine-type drugs*	*Cannabis-type drugs*	*Hallucinogens*	*Amphetamine-type drugs*	*Sedative-type drugs*	*Volatile solvents*
Africa							
Chad	0.2	<	0.6	0.1	0.5	0.5	0.2
Ghana	<	<	12.0	..	<	3.0	..
Mauritius	0.3	..	0.3	..	..	..	..
Namibia	..	..	2.0	..	..	2.0	0.7
South Africa	<	<	0.1	<	<	<	..
America							
Argentina	<	4.4	0.2	..	..	0.3	..
Bahamas	..	<	0.4	..	..	..	..
Boliva	0.9	0.2	..	<	..	1.8	2.8
Brazil	<1.0	2.0	15.0	<1.0	2.0	25.0	5.0
Canada	..	0.7	7.4	0.9	0.2	..	..
Chile	0.2	0.4	1.8	<	0.7	5.5	<
Colombia	<	0.3	0.8	..	0.2	3.4	0.3
Honduras	<	0.9	2.1	..	7.6	7.6	..
Mexico	<	0.1	0.3	<	0.3	1.3	0.2
Peru	..	0.3	0.6	..	..	..	0.8
United States of America	1.8	1.7	7.1	0.9	0.9	1.0	0.8
Asia							
Hong Kong	0.3	<	<	..	<	<	<
Lao People's Democratic Republic	0.9[a]	..	..	..	..	..	..
Malaysia	0.1	..	<	..	<	..	..
Maldives	0.6	..	0.2	..	..	0.1	..
Nepal	0.1	..	0.7	<	..	<	..
Europe							
Croatia	0.2	<	1.9	<	<	<	0.1
Czech Republic	<	<	1.5	0.2	0.1	..	0.1
Denmark	0.3[a]	0.3	3.4	..	0.6	2.7[a]	0.3
Finland	<	..	0.7	..	<	0.5	..
Germany	<	0.1	1.2	<	0.1	..	..

Country/territory	*Opiate-type drugs*	*Cocaine-type drugs*	*Cannabis-type drugs*	*Hallucinogens*	*Amphetamine-type drugs*	*Sedative-type drugs*	*Volatile solvents*
Liechenstein	<	<	0.4	<	<	..	..
Monaco	<	<	0.3	<	<	..	..
Netherlands	0.2[a]	..	4.4[b]	..	..	..	..
Norway	0.1	<	<	..	<	..	0.4
Portugal	0.6[a]	<	1.0[a]	..	<	0.2[a]	..
San Marino	<	<	0.1	<	<	<	..
Slovenia	0.3	..	>4.0	..	..	..	..
Sweden	<	<	0.1	<	0.2	<	<
Switzerland	0.3	0.4	2.4	..	..	..	..
Ukraine	0.3	..	..	..	..	..	<
Near and Middle East							
Israel	0.3	0.2	1.5	0.3	..	1.0	..
Jordan	0.2	<	0.2	..	<	0.6	0.1
Oceania							
Australia	0.3	0.7	10.3	1.3	1.7	0.5	0.3
Micronesia (Federated States of)	..	..	11.4	..	..	..	2.9
Papua New Guinea	..	<	23.5	..	..	22.9	<

Source: United Nations International Drug Control Programme.

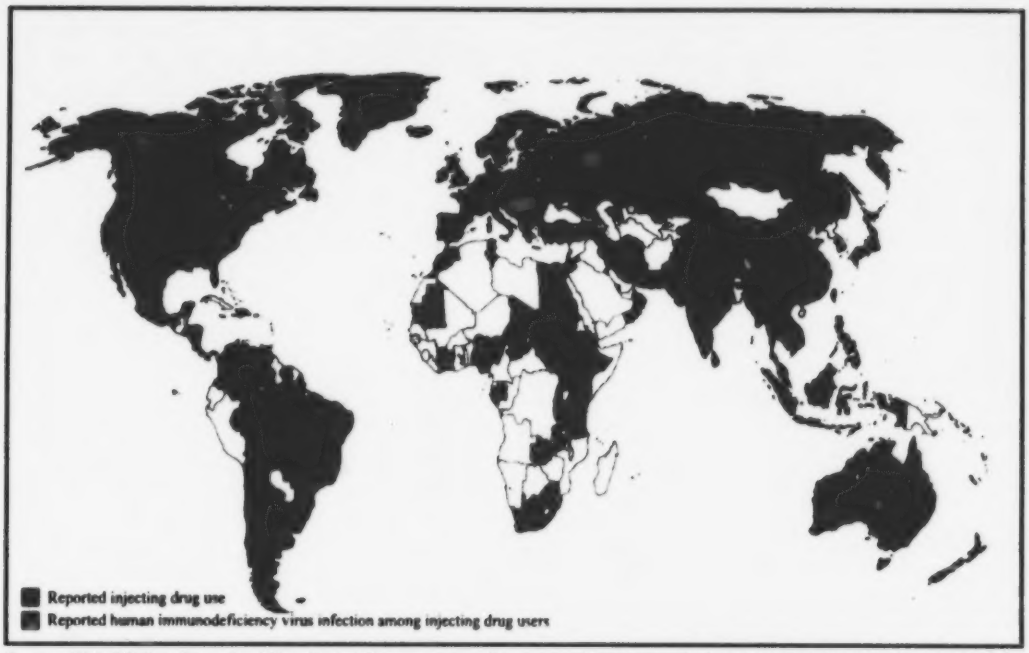
Notes: All figures rounded to one decimal (nearest tenth); (<) indicates lower than 0.1.

[a]Indicates daily abuse.

[b]Indicates monthly abuse.

(..) Indicates no data available.

Map 3. Countries and territories reporting injecting drug use and human immunodeficiency virus infection among injecting drug users[a/]



Sources: United Nations International Drug Control Programme, annual reports questionnaire, part II, Drug abuse (E/NR/1995/2); *AIDS 1994*, vol 8.
Note: The boundaries shown on this map do not imply official endorsement or acceptance by the United Nations.

[a/] The following countries reported injecting drug use, with those reporting human immunodeficiency virus among injecting drug users in italics:

Africa

Chad
Côte d'Ivoire
Egypt
Ethiopia
Gabon
Kenya
Mauritius
Morocco
Nigeria
Senegal
South Africa
Sudan
Tunisia
Uganda
United Republic of Tanzania
Zambia

Americas

Argentina
Bahamas
Bermuda
Bolivia
Brazil
Canada
Chile
Colombia
Costa Rica
Dominican Republic
Ecuador
El Salvador
Guatemala
Haiti
Honduras
Jamaica
Mexico
Nicaragua
Panama
Puerto Rico
Suriname
United States of America
Uruguay
Venezuela

Asia

Azerbaijan
Bahrain
Bangladesh
China
Hong Kong
India
Indonesia
Iran (Islamic Republic of)
Iraq
Israel
Japan
Jordan
Kazakstan
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Macao
Malaysia
Myanmar
Nepal
Oman
Pakistan
Philippines
Qatar
Republic of Korea
Saudi Arabia
Singapore
Sri Lanka
Syrian Arab Republic
Taiwan Province of China
Thailand
Turkmenistan
Viet Nam
United Arab Emirates
Uzbekistan

Europe

Albania
Austria
Belarus
Belgium
Bulgaria
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Germany
Greece
Hungary
Iceland
Ireland
Italy
Latvia
Liechtenstein
Lithuania
Luxembourg
Malta
Moldova (Republic of)
Monaco
Netherlands
Norway
Poland
Portugal
Romania
Russian Federation
San Marino
Slovakia
Slovenia
Spain
Sweden
Switzerland
Turkey
Ukraine
United Kingdom of Great Britain and Northern Ireland
Yugoslavia

Oceania

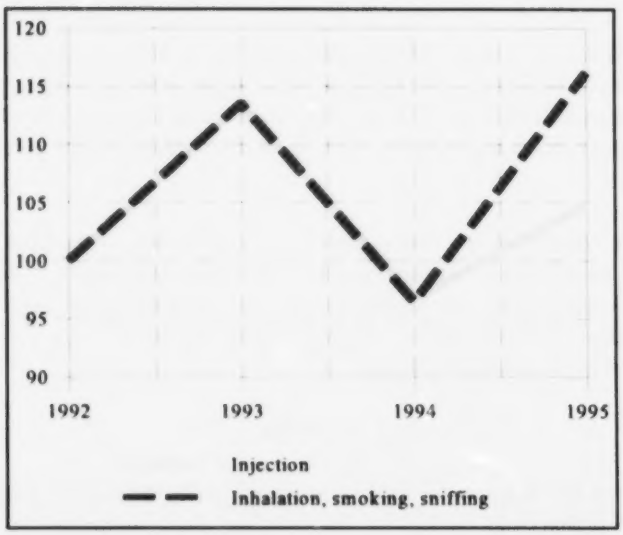
Australia
Fiji
Guam
Micronesia (Federated States of)
New Caledonia
New Zealand

20. Almost all the countries reporting injecting drug use also reported injection of opiate-type drugs (118 out of 121). Cocaine and amphetamine injecting was reported in Africa, east and south-east Asia, South America and eastern and western Europe. Injecting practices of amphetamine-type drugs were reported also in central Asia. Hallucinogen injection was reported in eastern Europe and South America.

21. According to the United Nations Joint and Co-sponsored Programme on HIV/AIDS (UNAIDS), about 5 to 10 per cent of HIV infections are the result of contamination through drug injection equipment. The exact extent of HIV infection among IDUs differs from country to country and from region to region. For example, in Viet Nam, where IDUs have been targeted for HIV testing, 72 per cent of the IDU population was found to be infected.[4] For Ukraine, where the number of HIV cases rose from 183 in 1994 to 5,360 in May 1996, 70 per cent of the infected individuals were injecting drug abusers.[5]

22. Reducing the number of people who begin to inject drugs could control HIV transmission to a certain extent. Once HIV has been introduced into a local community of injecting drug users, there is a possibility of extremely rapid spread. Furthermore, the group becomes a source of both heterosexual and perinatal transmission of HIV: research has demonstrated that among women having unsafe sex, sexual partners of male drug injectors have the highest risks of contracting HIV.[6] Figure I shows the reported trends in the mode of intake of heroin between 1992 and 1995.

Figure I. Trends in the mode of intake of heroin, 1992-1995



Source: Annual reports questionnaires received by the Secretary-General.

Note: Adjusted by the number of countries and territories reporting each year.

23. From the figure it can be seen that there is a slight increase in inhaling, smoking or sniffing as opposed to injecting. Several factors could have contributed to that situation. Research has shown that with the increased awareness of health risks associated with injecting drug use, such as HIV or hepatitis, some injectors have switched to non-injecting use of heroin. In addition, the tendency of those starting to abuse heroin is not to inject

at first. It may thus be that the rise in non-injecting practices actually reflects the rising trend in opiate abuse worldwide. A combination of all these factors could have contributed to the trend reflected in the data up to 1995.

24. A UNDCP/World Health Organization (WHO) study: Multi-City Drug Injecting and HIV Study 1994, on drug injecting behaviour and HIV infection in 13 cities, showed that injecting drug users do change their behaviour in response to information about HIV/acquired immunodeficiency syndrome (AIDS) and with access to the means for behaviour change. However, it appears to be more difficult to reverse an existing epidemic of HIV among IDUs than preventing an epidemic. The 50 countries and territories that have reported injecting drug use but no cases of HIV infection among IDUs should be considered high-risk areas with a need to develop appropriate strategies to prevent the spread of HIV among drug abusers.

25. Besides HIV/AIDS, hepatitis and tuberculosis are the most important infections among drug injecting users. The incidence of acute cases of hepatitis B (being some 10 times more infectious than HIV) has for long been considered to be an indirect indicator of the incidence of injecting drug use. More recently, the occurrence of hepatitis C among IDUs has attracted concern. Hepatitis C causes chronic hepatitis, cirrhosis and liver cancer. The hepatitis C virus has much in common with HIV. A person infected with hepatitis C becomes infectious for others, but it takes at least nine months before the infection can be confirmed by laboratory test. Screening tests have been developed but they are costly and are in practice not available in the particularly affected developing countries.

II. EMERGING PATTERNS AND TRENDS BY REGION

26. About 60 per cent of the countries that reported on trends in illicit consumption of drugs reported an increase or a large increase. Another 30 per cent reported a stable situation, while the remaining 10 per cent reported a decrease or a large decrease. Each drug shows a different pattern. Generally speaking, the abuse of amphetamines, cannabis and opiates seems to be on the increase, while the abuse of cocaine and hallucinogens is stable.

27. With few exceptions, countries reporting seizures of drugs usually also report illicit consumption of the same types of drug. One exception is benzodiazepines and barbiturate types of sedatives, for which many countries in South America report illicit consumption without corresponding reports of seizures. The reason may be that some of those drugs are domestically manufactured, but it may also be the result of insufficient enforcement of prescription rules and regulations.

A. Africa

28. Regular monitoring of the drug abuse situation is particularly uneven in Africa. Among the countries reporting, the main picture is that of an overall increase of drug abuse, with the possible exception of cocaine and hallucinogens, where the picture is more varied. Figure II shows the trends of reported abuse in Africa, by drug type, between 1992 and 1995.

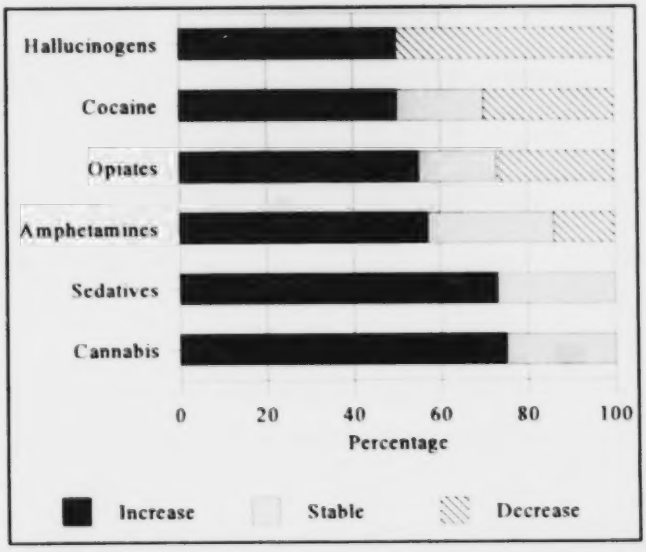
29. Cannabis grows wild and is cultivated in many African countries. Ethiopia, Morocco and South Africa are major producers of cannabis and eastern and southern African seaports are frequently used for the trans-shipment of cannabis resin from Asia to Europe or North America. Cannabis is widely consumed in all subregions of Africa. In 1995, a large increase in cannabis consumption was reported in Chad, the Congo and Kenya. Mauritius, Morocco and South Africa also reported increasing cannabis consumption. High rates of prevalence were reported by Ghana (12.2 per cent) and Namibia (2 per cent). There were no reports of decreasing abuse, but some African countries reported a stable situation.

30. The lack of effective control over the pharmaceutical supply system and the existence of illegal street markets at which pharmaceuticals are sold facilitate the availability of psychotropic substances. Both Chad and Kenya reported a large increase in the consumption of sedatives in 1995, while Morocco and South Africa reported some increase. There was no reported decrease in the abuse of sedatives in 1995. South Africa reported illicit consumption by injection. High but stable daily (1.1 per cent) and yearly (2.9 per cent) prevalence of illicit consumption of benzodiazepines was reported in Ghana. Namibia reported high but stable daily (1.3 per cent) and yearly (1.9 per cent) illicit consumption of methaqualone in 1995. However, methaqualone is known to be widely used in several countries in the region.

31. Increase in illicit consumption of amphetamine was reported by Chad, Congo, Côte d'Ivoire, Nigeria and South Africa. South Africa reported injection of amphetamine-type drugs. Chad reported a large increase, reaching an annual illicit consumption level of 0.5 per cent in 1995.

32. The trends with regard to abuse of hallucinogens are varied. About half of the countries reported a decrease, while the other half reported an increase. In Chad, where the abuse was reported to be on the increase, the annual prevalence was estimated at 0.13 per cent for 1995. South Africa also reported an increase in hallucinogen abuse in 1995.

Figure II. Africa: drug abuse trends, 1992-1995



Source: Annual reports questionnaires received by the Secretary-General.

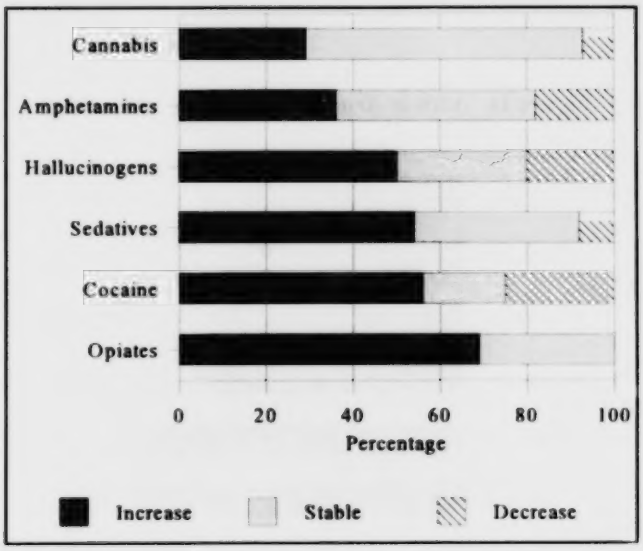
33. Heroin and raw and processed opium are transported from south-west and east and south-east Asia to African seaports and airports and on further to Europe and North America. Increased illicit consumption of opiate-type drugs was reported in Burkina Faso, Chad, Ghana, Kenya, Mauritius, Morocco, Namibia, Nigeria and South Africa. The illicit consumption of opiate-type drugs reported in Africa includes heroin, opium, morphine and synthetic narcotic analgesics. Heroin injection has been reported in Chad, Ethiopia, Mauritius, Morocco and South Africa, with Chad (0.2 per cent) and Mauritius (0.3 per cent) reporting annual prevalence rates equalling those reported in western Europe. HIV infection among injecting drug users has been reported in Morocco and Nigeria.

34. While cocaine trafficking has been spreading in recent years from South America via eastern, southern and western Africa to Europe, the trends with regard to consumption are not uniform. Half of the countries reported either a decrease or a stabilization of abuse, while an equal number of countries reported an increase. Illicit consumption of cocaine and crack was reported to be on the increase in Congo, Ghana, Morocco, Namibia, Nigeria and South Africa, while Chad reported a large decrease in cocaine consumption. South Africa reported the practice of cocaine injecting.

B. Americas

35. In the Americas, the most salient pattern is the increase in the abuse of opiates, alongside a stabilization of cannabis abuse. Figure III shows the reported trends of abuse in the Americas, by drug type, between 1992 and 1995.

Figure III. Americas: drug abuse trends, 1992-1995



Source: Annual reports questionnaires received by the Secretary-General.

36. Opium production on any significant scale was detected for the first time in 1988. Latin America accounts for more than two per cent of the global production of opium. An increase in the abuse of opiate-type drugs was reported by Argentina, Bolivia, Colombia, Costa Rica, Ecuador, Mexico and the United States. Countries reporting high annual prevalence of opiate abuse are the United States (1.8 per cent), Brazil and Bolivia (just under 1 per cent). In addition to the United States, Argentina and Colombia also reported heroin injecting.

37. As for cannabis, the annual prevalence for 1995 varies from 15 per cent (Brazil) to 0.008 per cent (Uruguay). In 1995, a large increase was reported by high-prevalence countries such as the United States (prevalence 7.1 per cent). Honduras (prevalence 2.1 per cent) also reported an increase in cannabis consumption in 1995. Except for Grenada, no other countries reported any decrease in cannabis consumption.

38. Cocaine abuse continued to rise in Costa Rica, Ecuador, Honduras, Paraguay and United States, but was reported to be stable in Canada, the Dominican Republic and Panama, and even decreasing in the Bahamas, Belize, Colombia and Grenada. The practice of cocaine injection was reported in Argentina.

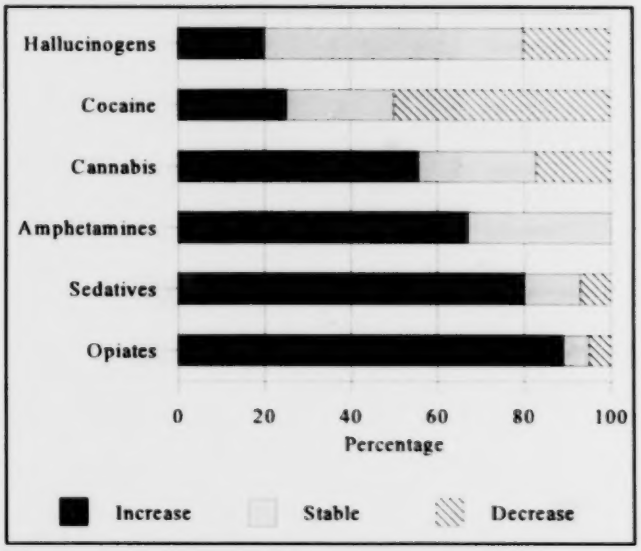
39. Honduras and Panama reported stable consumption of sedatives in 1995, whereas Argentina and the United States reported an increase in consumption.

40. A stabilization in the consumption of amphetamine-type stimulants was reported by Argentina, Honduras and Panama, while Colombia, Paraguay and the United States reported an increase in consumption.

C. Asia

41. The overall trend in Asia is an increase in the abuse of all drugs but cocaine and hallucinogens. The increase is particularly evident with regard to opiate-type drugs and sedatives, even though the prevalence figures for the latter are comparatively low. Pharmaceutical preparations containing narcotic drugs or psychotropic substances are still widely available throughout Asia without a medical prescription. Figure IV shows the reported trends of abuse in Asia, by drug type, between 1992 and 1995.

Figure IV. Asia: drug abuse trends, 1992-1995



Source: Annual reports questionnaires received by the Secretary-General.

42. Illicit cultivation of cannabis and opium poppy, opium production, heroin manufacturing and large-scale illicit trafficking in opiates constitute the major drug problem in Asia. Asia remains the major supplier of illicit opium, accounting for approximately 95 per cent of global production. Although opium and heroin smoking remains the major method of administration, there is increased reporting on injection of poppy straw extracts among members of the Commonwealth of Independent States (CIS). Heroin injecting practices have been reported in their annual reports questionnaires by India, Indonesia, Malaysia, Philippines, Sri Lanka and Uzbekistan. Half of the countries reporting injecting drug use also reported HIV infection among the injecting drug abusers (see map 3, p.10).

43. Illicit consumption of sedatives, mainly barbiturates and benzodiazepines, seems to be on the rise, a persistent phenomenon that can be linked to the lack of control of prescription. The situation is also reflected in the continued abuse of cough syrups containing codeine.

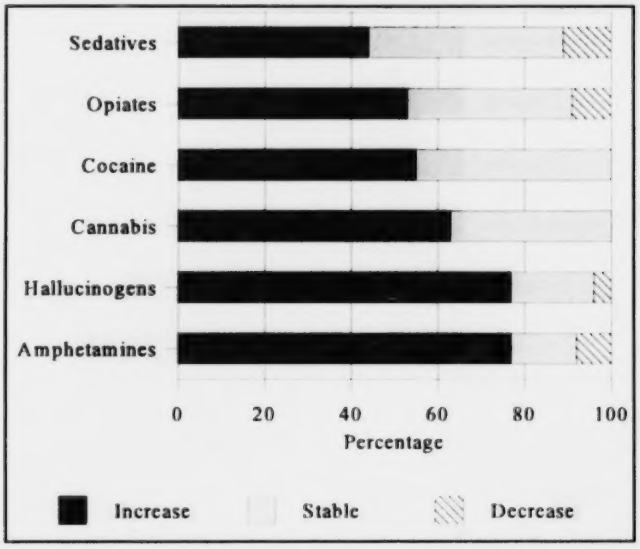
44. The abuse of cocaine has been reported as stable, with the exception of Indonesia and Singapore, where an increase has been reported, and the Philippines, where a large decrease was reported.

45. Amphetamine abuse continued to increase in Hong Kong, India, Indonesia, Japan, Philippines, Republic of Korea and Thailand. In the Far East, the most frequently abused stimulant is methamphetamine. In the Philippines, methamphetamine (*shabu*) is reported to have replaced cannabis as the most widely abused substance.

D. Europe

46. The rapid transition in central and eastern Europe, States members of CIS and the Baltic States has contributed to an increase in drug abuse in the region. The dominant trends in Europe are increases in the abuse of amphetamines (including MDMA) and hallucinogens, followed by cannabis, cocaine and opiates. Figure V shows the reported trends of abuse in Europe, by drug type, between 1992 and 1995.

Figure V. Europe: drug abuse trends, 1992-1995



Source: Annual reports questionnaires received by the Secretary-General.

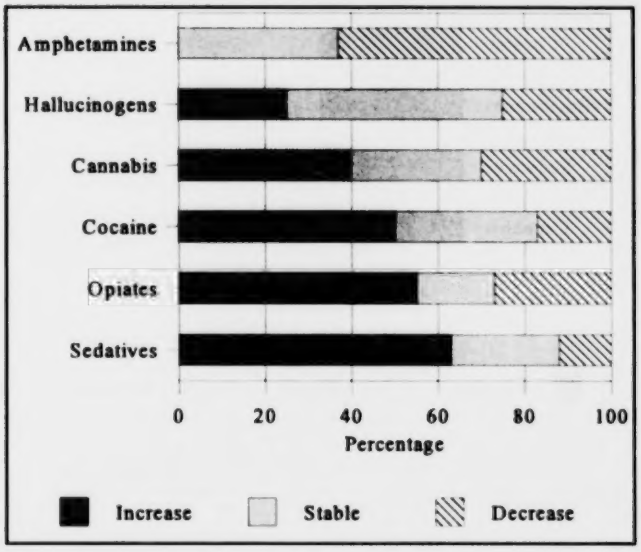
47. In western Europe, abuse of amphetamines continues. The fastest growth rates are reported for MDMA. The countries most affected are the United Kingdom of Great Britain and Northern Ireland and Denmark (0.6 per cent annual prevalence), followed by the Benelux countries, Sweden (0.2 per cent) and Germany (0.1 per cent). Large increases in the abuse of amphetamines have been reported by Belgium, Germany, Iceland, Liechtenstein, Lithuania and Monaco. Another synthetic designer drug, sodium oxidate (*gamma*-hydroxybutyrate (GHB), also known as "liquid X" or "fantasy") is beginning to show in Europe. Large increases in cannabis abuse were reported in 1995 by Belarus, Belgium, Lithuania and the Republic of Moldova.

48. Heroin injecting was reported on the annual reports questionnaire by Belarus, Belgium, Czech Republic, Denmark, France, Italy, Liechtenstein, Luxembourg, Norway, Portugal and Switzerland. Cocaine injecting was reported in Czech Republic, France, Liechtenstein, Luxembourg and Switzerland. Injecting of amphetamine-type drugs was reported by Belarus, Belgium, Czech Republic, France, Lithuania, Luxembourg, Republic of Moldova, Russian Federation, Sweden and Switzerland.

E. Near and Middle East

49. The drug abuse reporting was very sketchy in this region. It seems that opiates and non-opiate sedatives are the two major types of drugs abused in the region, followed by cannabis and cocaine. Both opiates and sedatives were reported to be on the increase. The patterns with regard to cocaine and cannabis consumption varied. Figure VI shows the reported trends of abuse in the Near and Middle East, by drug type, between 1992 and 1995.

Figure VI. Near and Middle East: drug abuse trends, 1992-1995



Source: Annual reports questionnaires received by the Secretary-General.

50. Heroin abuse was reported by Islamic Republic of Iran, Iraq, Israel, Jordan, Oman, Syrian Arab Republic and United Arab Emirates. The annual prevalence rates were estimated at 0.5 per cent for the Islamic Republic of Iran and 0.2 per cent for Jordan. Injecting practices were reported in Israel, Jordan, Qatar, Turkey and United Arab Emirates.

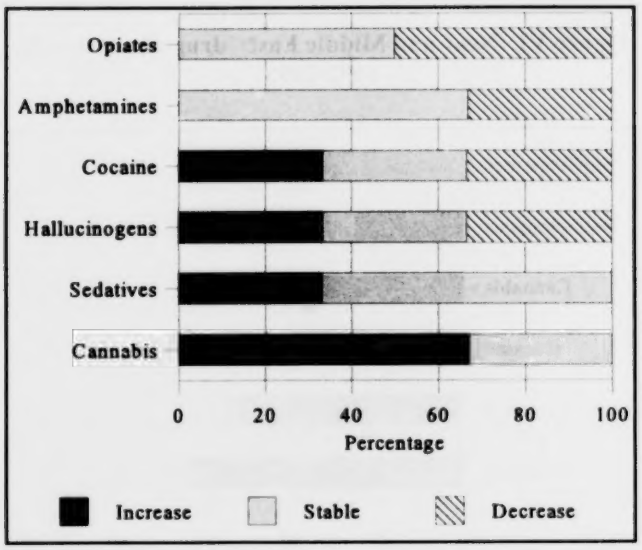
51. Increase in cocaine abuse was reported in Israel, the Syrian Arab Republic and Turkey. No increase in the illicit consumption of amphetamine was reported.

F. Oceania

52. The most frequently reported drug consumed in this subregion is cannabis. There were no reports on decrease of consumption. This was also true for non-opiate sedatives. Figure VII shows the reported trends of abuse in Oceania, by drug type, between 1992 and 1995.

53. The Federated States of Micronesia, Papua New Guinea, Fiji and New Zealand reported increasing cannabis consumption. The annual consumption prevalence was estimated at 10.3 per cent in Australia, 11.4 per cent in the Federated States of Micronesia and 23.5 per cent in Papua New Guinea. While both Australia and New Zealand reported stable cocaine consumption, Papua New Guinea reported an increase in consumption each year from 1992 to 1995.

Figure VII. Oceania: drug abuse trends, 1992-1995



Source: Annual reports questionnaires received by the Secretary-General.

54. In Australia, amphetamine continues to be the most commonly used illicit drug after cannabis. Ecstasy has been reported to be popular among those involved in the "rave" scene.

55. Australia is the only country in the region that reported abuse of opiate-type drugs. However, the geographical location of Oceania as a drug transit point between producers in Asia and markets in the Americas creates a vulnerable situation.

III. YOUNG PEOPLE AND DRUG ABUSE

56. The Convention on the Rights of the Child (General Assembly resolution 44/25, annex) defines a child as being a person under the age of 18. The definition is a recognition of the physical and psychological vulnerability of the growing person. Children and adolescents need protection from conditions that may damage

their health and development, like child labour and dependence-producing substances. Article 33 of the Convention states:

> "State Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances."

57. Drug abuse by young people seems to be on the increase in most parts of the world. An increase in cannabis abuse has been reported by many countries in Europe. For example, the United States reported an upward trend in marijuana use among 11th- and 12th-grade students between 1992 and 1995 and a doubled prevalence among 8th-grade students during the same period.[7] While it is difficult to obtain actual numbers, Governments in Africa and in Oceania have reported that in addition to the traditional consumption of cannabis by older persons there is increasing abuse among younger persons.

58. Opiate-type drug abuse is growing in almost all regions of the world, particularly in Europe and in North America. For example, Slovakia has reported a rapid increase in heroin abuse since 1990, especially among youth.[5] Increasing opiate abuse, particularly among youth, has been reported by countries in central Asia where injection of poppy straw extracts is the prevalent form of abuse. In the United States, the prevalence of heroin abuse among eighth-grade students rose from 0.7 per cent in 1992 to 1.4 per cent in 1995.[7]

59. There is a large and growing number of "recreational" users of amphetamine-type stimulants, the prevalence of which is similar between males and females. In Thailand, where the number of abusers of amphetamines has been estimated at 260,000, the increasing abuse of amphetamine among teenagers is of concern to national authorities.[5]

60. Globally, there is a greater availability of drugs and, at the same time, an increased variety. The drug abuse behaviour patterns are becoming more homogeneous around the world. Through media such as radio, musical concerts, television, videos, youth magazines and information technology, a significant proportion of the world's youth population is being exposed to a culture that is more tolerant towards the use of drugs. It can no longer be argued that drug abuse is taking place only among marginalized groups of young people or mainly in the Western industrialized world.

61. Furthermore, there are indications that the initiation into drug abuse is more frequently taking place at an earlier age than before. With the exception of cocaine and sedatives, those seeking treatment for drug abuse problems are getting younger. This trend is especially notable among people seeking treatment for opiate abuse: during 1995 more young people in the age group 15-19 entered treatment than during the whole three-year period of 1992-1994. In the United States, almost two thirds of the LSD abusers seeking treatment in 1995 were under the age of 20.[5]

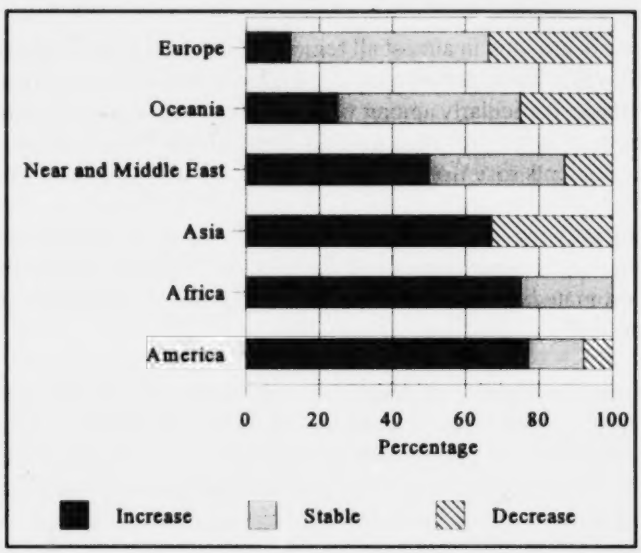
62. The growing popularity of drugs such as methamphetamine, ecstasy and other amphetamine-type stimulants in western Europe, North America and in some countries of eastern Europe and east and south-east Asia is of particular concern. These are drugs closely associated in some countries with the "rave" or dance scene, which is particularly attractive to young people. Despite the harm they can do, including several deaths ascribed to the abuse of ecstasy, these drugs paradoxically enjoy a more benign image than plant-based stimulants.

63. It has been argued that there are certain specific factors underlying the growing popularity of amphetamine-type stimulants, such as a more competitive society with increased needs for ever higher levels of stimulation, reduced family ties and a decline in traditional belief systems. Growing levels of unemployment further alienate young people from the older generations. It is evident that prevention strategies need to take

these factors into consideration and that young people themselves need to play a central role in developing and implementing prevention measures in order to ensure that they reach their intended audience.

64. Volatile solvents (inhalants) are not subject to international control measures, but they may function as a gateway to narcotic drugs and psychotropic substances, in particular among rather young people in especially difficult circumstances, such as street children. In the United Kingdom, for example, solvent abuse is largely confined to children between the ages of 12 and 17 years, peaking around 14 or 15 years. The lifetime prevalence of volatile substance abuse among adolescents globally has been estimated at 4 to 24 per cent. Figure VIII shows the reported trends in volatile solvent (inhalants) abuse, by region, between 1992 and 1995.

Figure VIII. Volatile solvents (inhalants): trends in abuse, by region, 1992-1995



Source: Annual reports questionnaires received by the Secretary-General.

IV. RESPONSES TO DRUG ABUSE

A. Overall responses: strategies

65. In its resolution 42/112 of 7 December 1987, the General Assembly urged Governments to take due account of the framework provided by the Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control[8] when formulating programmes to fight drug abuse and illicit trafficking. In paragraph 15 of the Global Programme of Action, adopted by the General Assembly in its resolution S-17/2 of 23 February 1990 and annexed to that resolution, the Assembly requested the Secretariat to submit, by 31 December each year, a succinct questionnaire to all Governments asking for details of action taken with regard to the seven targets set out in chapter I of the Comprehensive Multidisciplinary Outline covering data collection and prevention activities. The revised part II of the annual reports questionnaire implemented since 1992 contains those questions and questions on the seven treatment targets included in the Comprehensive Multidisciplinary Outline by the Commission on Narcotic Drugs.

66. In the present chapter, the responses to the recommendations of the Comprehensive Multidisciplinary Outline - as reported by Governments through the annual reports questionnaire - are described. Not many details have been provided by Governments. One reason for this may be that the responsibility for implementing demand reduction activities is often decentralized to the local level and such activities are also undertaken by civil society. Nevertheless, a review of the responses indicates certain trends in the different countries with regard to prevention, treatment and rehabilitation.

67. The Comprehensive Multidisciplinary Outline firmly emphasizes the necessity to adopt a balanced approach in dealing with illicit demand, supply and trafficking. This means involving many branches of the national government machinery and also institutions of higher learning, research and other academic bodies and private sector organizations.

68. Information provided through the annual reports questionnaires shows that many countries have a coordinating body on matters related to drug abuse and control. However, a clearly articulated national drug strategy addressing the balance of supply of and demand for drugs is far from universal. Even where a national drug control coordinating body existed, many countries reported the challenge of their tasks in the face of both budgetary and human resource constraints.

B. Data collection

69. Targets 1 and 2 of the Comprehensive Multidisciplinary Outline deal with the assessment of the extent of drug abuse and the organization of comprehensive systems for the collection and evaluation of data. The Outline suggests that countries lacking systems for estimating the extent of drug abuse could develop such systems by stages and that training programmes should be established for personnel involved in the collection and analysis of data. It furthermore recommends that countries provide for systematic collection of data on subpopulations of drug abusers from records of the police, registries of deaths, hospital emergency rooms, drug treatment centres, prisons, mental hospitals, psychiatric clinics, social security and welfare organizations and so on.

70. Of the 90 countries answering the annual reports questionnaires, 29 reported having some kind of drug abuse data registry or some form of central or national drug abuse data collection system. Among those countries, 14 are located in western and central Europe, 7 in Asia and 5 in the Americas. Two countries in the Near and Middle East and one country in Africa reported having such a drug abuse data system.

71. Among the countries having a national drug abuse data collection system, resources and capabilities available varied greatly. In some there were core staff with computer facilities; in others there was a lack of funding and training for personnel in the basic skills to maintain such a system. Most of the countries reported a need to improve coordination among the different sectors from which the data were to be gathered. There was evidence of a lack of sharing of information among different bodies responsible for collecting drug abuse data and those holding different elements of the data. The consequence is that existing national systems contain incomplete data.

72. There was a variety of reasons given why certain countries did not have a national drug abuse data collection system. Some countries reported that drug abuse was non-existent in their country and there was therefore no drug abuse data collection system. In others, there was a recognized need but an absence of resources with which to establish systems.

73. A national drug abuse data collection system is one way of routinely gathering drug abuse data. Periodic or one-time studies were reported by 29 countries to supplement gaps in data or to try to compensate for the lack of a routine data collection system. In all, 13 European countries, 8 countries in the Americas, 4 in the Near and Middle East, 3 in Africa and 1 in Asia reported having conducted surveys at one time or another.

74. The next most frequently conducted type of study is qualitative or descriptive studies of drug abuse, that is, studies seeking to describe people or situations rather than focusing on numbers or statistics. A total of 20 countries reporting having conducted such studies on drug abuse, 9 of them in Europe, 6 in the Americas, 4 in Africa and one in Asia. General population or target population attitude surveys have been reported by 17 countries, with 9 in Europe and 4 in the Americas, 3 in Africa and one in the Near and Middle East region.

75. Studies on the economic cost of drug abuse to society and to individuals have been reported by four countries, two in Europe, one in the Americas and one in Asia.

C. Prevention responses

76. Targets 3 to 7 of the Comprehensive Multidisciplinary Outline deal with prevention. The Outline recommends, *inter alia*, that drug abuse prevention curricula and instructional materials be developed for all levels of educational institutions and that the benefits of a healthy drug-free lifestyle be emphasized. Teacher education and motivation are considered essential. The Outline also recommends that local government authorities promote drug-free leisure-time activities such as drug-free cultural and sporting activities. Civic groups, especially those directly concerned with youth, should disseminate information about the dangers of drug abuse and law enforcement agencies should, where appropriate, participate in information activities. It is further recommended that voluntary organizations be asked to provide preventive education, counselling, guidance, treatment and rehabilitation.

77. With regard to prevention in the workplace, the Comprehensive Multidisciplinary Outline suggests that training workshops be set up for supervisors, programme developers and others and that information be publicized in the workplace warning of the risks of drug abuse. Employers and workers'organizations should develop joint action programmes to discourage drug abuse.

78. Furthermore, the Outline recommends that workshops and briefings for media personnel be convened to increase their knowledge of drug abuse and that guidelines be provided in the form of codes of conduct to be observed when portraying events involving drug abuse.

79. Based on the data provided in the annual reports questionnaires, it appears that school activities, especially in secondary schools, are the most widespread form of prevention across the world. Approaches were reported to focus on factors that can lead to drug taking or that can protect young people from drug use. Examples of preventive activities in schools reported by countries included seminars, workshops, displays, exhibits, distribution of printed material, audio-visual presentations, essay competitions and role model programmes. Very little was reported on leisure-time activities as a tool of prevention, but some countries reported on sports and music events as alternative leisure activities.

80. Although street children and school drop-outs are recognized as being at the highest risk for drug abuse, only few activities such as provision of shelter and recreational centres were reported to target those groups. Where programmes for street children did exist, alternative activities and counselling were provided. For school drop-outs, non-formal education programmes were mentioned, as were vocational rehabilitation and counselling.

81. Parent-teacher associations and ex-drug abuser self-help groups have been by far the most active civic groups in drug abuse prevention at the community level. Law enforcement agencies sometimes collaborate with civil society in such activities. Programmes in the form of lectures and seminars to sensitize parents and make them aware of the problem of drug abuse have been reported by several countries. Other themes have been effective parenting and prevention in the family. Civic groups have also been responsible for preventive activities directed at young people, such as youth leadership training, preventive education, community activities and peer counselling.

82. Preventive programmes in the workplace are more likely to be available in large enterprises with over 500 employees than in small businesses, but very little was reported by Governments on such programmes even though some countries are known to have structured prevention programmes in the workplace. The types of workers identified by countries as being at high risk of substance abuse are taxi drivers, long-distance truck drivers, construction workers, tourist industry workers, including workers in restaurants and hotels, bar, nightclub and discotheque workers, foreign and migrant workers, miners, businessmen, housewives, refugees, sex workers, factory workers, fishmongers and dock workers.

83. With regard to the role of the media, in Africa, the Americas, Asia, western Europe and the Near and Middle East, ministries, health professionals and sometimes law enforcement agencies were reported to cooperate either formally or informally by providing information and by giving television or radio interviews. In a few cases, private companies and non-governmental organizations in south Asia, North America and the Near and Middle East collaborate with the media for drug abuse prevention campaigns.

D. Treatment, rehabilitation and social reintegration responses

84. The Comprehensive Multidisciplinary Outline points out that a policy for treatment must include counselling, guidance, motivation, treatment in the medical sense, rehabilitation and social reintegration, and should ideally culminate in the drug addict's return to a drug-free life. Particular stress is laid on multidisciplinary aspects.

85. Targets 29 to 33 and 35 deal with treatment and rehabilitation issues, while target 34 deals with care for drug-addicted offenders within the criminal justice and prison system. The Outline proposes that national authorities consider, where appropriate, establishing a nation-wide coordinating body to be responsible for coordinating and giving guidance to the development and maintenance of a comprehensive national treatment programme for drug addiction. Once a treatment policy has been adopted, an inventory of existing treatment facilities should be drawn up to enable their monitoring. The Outline also recommends that evaluation be made of the efficacy of different treatment methods. Treatment programmes should be "individualized" and geared to the drug addict's genuine problems and involve, as appropriate, his or her family. Training should be provided for specific groups of professionals, volunteers and community leaders. "Transit" institutions in which former drug addicts could be trained to lead an appropriate lifestyle should be established. Youth movements, sport clubs and religious organizations should contribute towards rehabilitation and social reintegration. The public health authorities should collect data on different contagious diseases among drug users, transmission and means of halting the transmission. Experts should be invited to study possible prophylactic measures that would not promote or facilitate drug abuse.

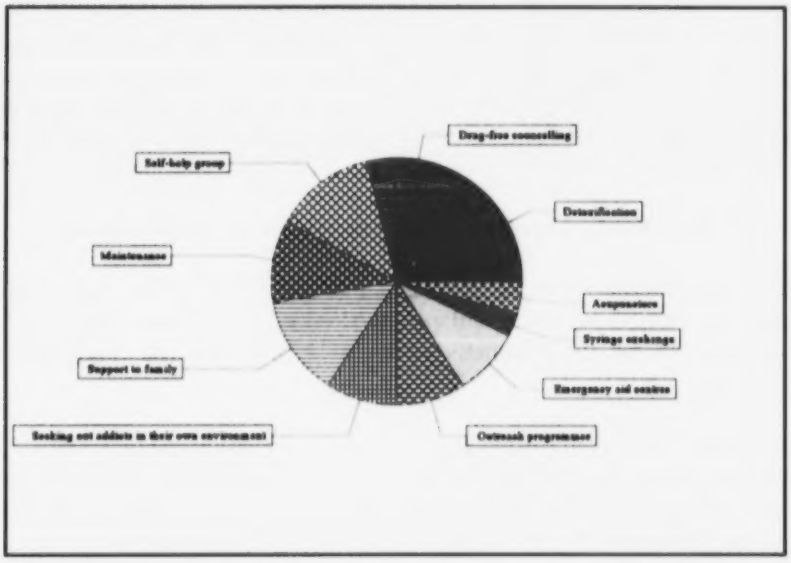
86. Most countries responding to the annual reports questionnaires stated that they did not have an articulated treatment policy. Treatment for drug abuse is carried out in psychiatric hospitals, in general hospitals and in residential treatment centres. In some countries, ambulatory mental health care is available, as are day-care centres, 24-hour crisis centres and half-way houses. In addition to medicated detoxification treatment, traditional medicine models exist in some countries. Acupuncture treatment is available in some countries in eastern and western Europe, Asia, the Americas and in private services in the Near and Middle East and in one country in Africa. Figure IX shows the distribution of types of treatment programmes available as reported by Governments in the annual reports questionnaires.

87. Even though therapeutic communities still exist in some countries, the trend, particularly in southern Europe, is moving towards shorter stays, greater professionalism, individualized therapy and more emphasis on helping people to prepare themselves for independent living after treatment.

88. Substitution or maintenance programmes were reported by 28 of the 90 countries answering the annual reports questionnaires for 1995: Belgium, Canada, Colombia, Czech Republic, Denmark, Dominican

Republic, France, Greece, Honduras, India, Indonesia, Iran (Islamic Republic of), Ireland, Israel, Italy, Jordan, Lithuania, Luxembourg, Mauritius, Norway, Panama, Paraguay, Portugal, Republic of Moldova, Singapore, Switzerland, United Kingdom and United States.

Figure IX. Types of treatment programmes available



Source: Annual reports questionnaires received by the Secretary-General.

89. An additional 21 States and territories were identified by a recent UNDCP survey as having some kind of maintenance programme: Australia, Austria, Azerbaijan, Croatia, Finland, Germany, Guatemala, Hong Kong, Iceland, Kyrgyzstan, Latvia, Lithuania, Malta, Mexico, Monaco, Morocco, Netherlands, Oman, Slovenia, Spain and Sweden. Methadone was by far the most commonly prescribed drug for maintenance purposes. Other drugs used for such purposes were buprenorphine, codeine, dihydrocodeine, heroin, *l*-alpha acetylmethadol (LAAM), morphine and pethidine.

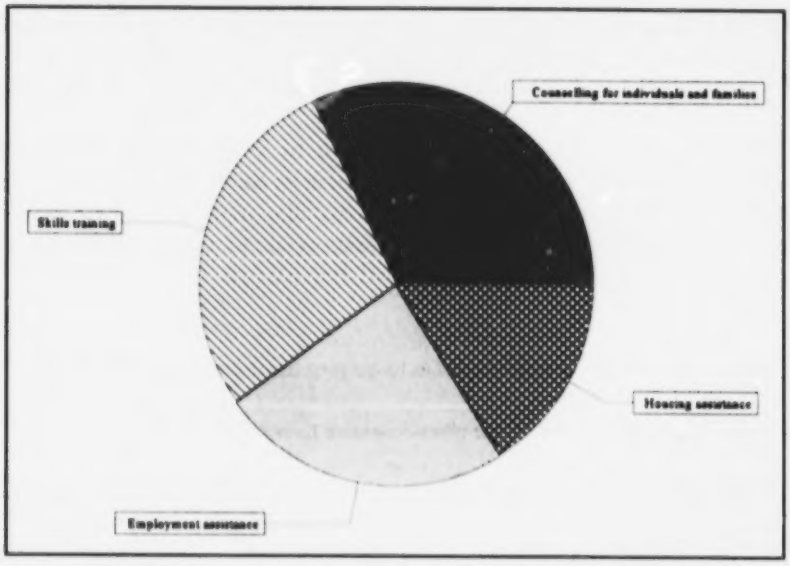
90. Policies on reducing the transmission of contagious diseases by providing clean injecting equipment differ between countries. A total of 11 countries reported in the questionnaire that they had syringe and needle exchange programmes, 7 of them in Europe, 2 in the Americas and 2 in Asia.

91. In general, based on information received, social reintegration seems to be the least addressed aspect of demand reduction. Among countries reporting having social reintegration programmes, the interventions can be classified into four categories in order of the availability of services: (a) counselling for treated drug-dependent persons and their families; (b) training; (c) assistance in seeking employment; and (d) assistance in securing housing. Figure X shows the distribution of the types of social reintegration programmes available as reported by Governments.

92. According to the provisions of the Singe Convention on Narcotic Drugs of 1961[9] as amended by the 1972 Protocol[10] (art. 36, para. 1 (b), and art. 38, para. 1) and the Convention on Psychotropic Substances of 1971[11] (art. 20, para. 1 and art. 22, para. 1 (b)), parties should consider providing, either as an alternative to conviction

or punishment or in addition to punishment, treatment, education, aftercare, rehabilitation and social reintegration for drug abusers.

Figure X. Types of social reintegration programmes available



Source: Annual reports questionnaires received by the Secretary-General.

93. Demand reduction programmes and treatment support for prisoners with drug-related problems are not commonly available. Furthermore, training for criminal justice, correctional and law enforcement personnel on how to deal effectively with drug-dependent people is not widely available. Even less common are explicit policies, procedures or guidelines for such personnel.

V. CHALLENGES IN DRUG ABUSE DATA COLLECTION

94. The history of the International Drug Abuse Assessment System (IDAAS) goes back to the 1980s. It was felt then that better use could be made of the information that Member States were obliged to submit to the United Nations. There was also a need for information of a better quality. The issue was discussed at the International Conference on Drug Abuse and Illicit Trafficking, held at Vienna from 17 to 26 June 1987, where it was agreed that methodologies should be developed and systems instituted for assessing prevalence and trends of drug abuse on a comparable basis.

95. The issue was also raised in paragraph 13 of the Global Programme of Action (General Assembly resolution S/17-2, annex), in which it was stated that States should establish and promote national systems to assess the extent of drug abuse and to collect data on trends of abuse. The Assembly requested the former Division of Narcotic Drugs to establish a database concerning the nature and extent of drug abuse at the international level.

96. IDAAS was set up to collect and analyse existing data. It is thus dependent on the information that Governments provide, either through the annual reports questionnaires or through supplementary reports provided by Governments of results of surveys and research studies conducted in their countries. Part II of the

present questionnaire was devised specifically for the System by a group of international experts and approved by the Commission on Narcotic Drugs at its thirty-fourth session, in May 1991. The response rate has been disappointing: during the period from 1992 to 1995 it never exceeded 50 per cent and the response rates to individual items also vary.

97. There may be several reasons for the poor response rate. Countries vary in their ability to collect information on the drug abuse situation. Many countries simply do not have a national drug abuse data collection system, while others may have statistical systems or registries on which indirect indicators could be based but lack sufficient coordination to be able to form a consistent picture of the drug abuse situation.

98. It is, however, evident that the questionnaire itself is felt to be complicated and difficult to fill in. This has been recognized by the Commission on Narcotic Drugs, which in its resolution 1994/3 of 20 July 1994 requested a review and integration of all annual reports questionnaires, using modern communication and presentation techniques, to make such changes in format as may be appropriate to achieve optimum acceptability and to facilitate their use. A review of the questionnaire is now being carried out within UNDCP. A working group has been set up:

(a) To take stock of information requirements to be met through the questionnaire;

(b) To review the appropriateness of the questionnaire to meet those requirements;

(c) To review the format of the questionnaire and its current division in parts and sections;

(d) To review the relevance and clarity of the individual questions asked and of the drug control terminology used;

(e) To make recommendations as necessary to improve the system and to secure more numerous responses and data of a better quality.

99. Simplifying the annual reports questionnaire would be a necessary but insufficient step toward an increased coverage and enhanced quality of IDAAS. Few countries have monitoring systems that allow them to identify and tackle drug abuse problems in an effective way. To alleviate the situation, UNDCP assists countries in carrying out rapid assessment studies to serve as a basis for programming exercises. Since 1992, such studies have been carried out in Bangladesh, Bolivia, Cameroon, Chile, Czech Republic, Ecuador, Ethiopia, Kenya, Myanmar, Nepal and Viet Nam. The rapid assessment methodology has proved to be very useful for programming purposes, since it provides means to get a fairly full picture of the drug abuse situation at a given time and the actual and potential resources to tackle it. It cannot, however, replace systematic monitoring of a country's drug abuse situation.

100. Targets 1 and 2 of the Comprehensive Multidisciplinary Outline recommend that countries that have not yet done so develop systems for estimating the extent of drug abuse. Repeated studies or surveys are valuable but often costly ways to monitor trends and patterns in drug abuse. Such trends can also be monitored through the use of indirect indicators based on routine statistics from health, social welfare or enforcement sectors.

101. On the one hand, capacity building in this field, as in other fields, has to be sensitive to the situational context and should be done in accordance with institutional and legislative requirements at the national level. On the other hand, in the development of national monitoring systems, proper consideration should be given to the question of compatibility between different systems within a country and between systems in different countries.

102. In most parts of the world there are regional and national networks of epidemiologists and epidemiology work groups, like the Asian Epidemiology Work Group, that discuss issues of common concern, organize training and in some cases also develop instruments for common reporting. Some of them are linked together in the International Substance Abuse Epidemiology Network.

103. The Comprehensive Multidisciplinary Outline recommends that regional organizations make comparative studies of drug abuse patterns in their region and that they establish training programmes for people engaged in epidemiological surveys. This is being done increasingly. At the European level, the decision by the Pompidou Group of the Council of Europe in 1981 to set up a working group of experts of epidemiology was based on the need for valid data comparable both within and between European countries in order to define policies. It has developed new research instruments and improved existing ones. It has also set up a multi-city monitoring network that has provided a common methodological basis for the collection, collation and evaluation of data on drug abuse at the city level. UNDCP collaborates with the Pompidou Group to expand the network to cities in eastern Europe and to introduce the participatory data-generation techniques of the rapid assessment methodology.

104. The European Monitoring Centre on Drugs and Drug Addiction at Lisbon has been set up to provide member States of the European Union and the European Commission with objective, reliable and comparable information at the European level concerning drugs, drug addiction and their consequences. In order to improve comparability and quality of data, the Centre recommends the establishment of key indicators and core data. The work will start with an in-depth examination of the comparability of definitions and key terms at the European level. An agreement has been made between UNDCP and the Centre to strengthen the coordination between them with a view to enhancing the cost-effectiveness of data collection and improving comparability between the data collected by the two bodies.

105. In the Americas, the Inter-American Drug Abuse Control Commission of the Organization of American States has recently developed a uniform statistical system and software to gather information from different sources such as treatment centres and emergency rooms across the region. Furthermore, a system for epidemiological surveillance of drug abuse has been established for Central America. Elements of the same system are currently being implemented in some countries in Latin America.

106. IDAAS should be seen as a comprehensive system where inputs from the national, regional and international levels are equally important. If one part of the system is weak it affects the whole system. In order for it to function better, action needs to be taken at all three levels.

VI. ISSUES FOR CONSIDERATION BY THE COMMISSION ON NARCOTIC DRUGS

107. The present report has identified issues of relevance to the functioning of IDAAS which is a system for compiling, analysing and reporting existing data and information provided by Governments. The response rate to the annual reports questionnaire is rather disappointing. There are gaps in knowledge with regard to certain items such as the number of estimated daily abusers, treatment data and registered deaths. A large amount of epidemiological data exists in addition to what is provided by Governments. However, the scientific quality of the data is variable and not always known.

108. In addition to epidemiological data, the annual reports questionnaire gathers information about demand reduction activities in response to the recommendations of the Comprehensive Multidisciplinary Outline. While conditions generally do not change very often, Member States are requested to answer questions regarding data collection, prevention, treatment and rehabilitation every year.

109. In the light of the above, the Commission on Narcotic Drugs is invited to give its view on:

(a) The use of alternative sources of information to supplement annual reports questionnaire information;

(b) The frequency of reporting on the implementation of the targets of the Comprehensive Multidisciplinary Outline.

Notes

[1]*Monthly Bulletin of Statistics*, vol. L. No. 7 (July 1996).

[2]A. R. Moss and others, "HIV seroconversion in intravenous drug users in San Francisco, 1985-1990", *AIDS 1994*, vol. 8, pp. 223-231.

[3]*AIDS 1994*, vol. 8, pp. 1745-1756 and *HIV/AIDS Surveillance in Europe, 1996/2.*

[4]"Indicative statistics on illicit drug production, trafficking and abuse in Viet Nam", United Nations International Drug Control Programme, October 1996.

[5]*Report of the International Narcotics Control Board for 1996* (United Nations publication, Sales No. E.97.XI.3), paras. 216 and 333.

[6]"Women and drug abuse" (E/CN.6/1994/BP.1, February 1994), p. 10.

[7]United States of America, Department of Health and Human Services, Public Health Service, National Institutes of Health, *National Survey Results on Drug Use from the Monitoring the Future Study, 1975-1995*, vol.1, "Secondary school students" (NIH Publication 96-4139), Washington, D.C., 1996, p. 112.

[8]See *Report of the International Conference on Drug Abuse and Illicit Trafficking, Vienna, 17-26 June 1987* (United Nations publication, Sales No. E.87.I.18), chap. I, sect. A.

[9]United Nations, *Treaty Series*, vol. 520, No. 7515.

[10]Ibid., vol. 976, No. 14152.

[11]Ibid., vol. 1019, No. 14956.